Idaho Medical Home Collaborative

Final Recommendations

TRANSFORMED, LLC

May 29, 2015

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Executive Summary

Created By Governor Otter in 2010 by Executive Order 2010-10 and overseen by the Idaho Department of Insurance (DOI), the Idaho Medical Home Collaborative (IMHC) is a collaboration of primary care physicians, private health insurers, healthcare organizations and Idaho Medicaid. They are charged with making recommendations to the governor on the development, promotion, and implementation of a patient-centered medical home (PCMH) model of care statewide- including PCMH definition, provider qualifications and standards, payment methodologies, consumer and provider engagement, care coordination and case management guidelines, health data exchange and evaluation measures, including cost- and quality-based outcomes measures.

Following an application process and notification of practice acceptance in October of 2012, a pilot project commenced in January of 2013 to assess methods and the impact of PCMH implementation. A multi-payer project including Idaho Medicaid, Blue Cross of Idaho, Pacific Source and Regence Blue Shield, the project established baseline requirements and provided both financial and technical support to 36 practices over the course of the next year. TransforMED, LLC (a wholly owned subsidiary of the American Academy of Family Physicians) was selected under a competitive-bid process to conduct a summative analysis of the pilot project. This final report provides an overview of that evaluation, including the key questions answered, data sources, analytic variables and claims-based evaluation outcomes.

Prior to this Final Summary Report, 2 previous Preliminary Reports have been submitted:

"Preliminary Report: Survey & Self-Reported Findings"

This preliminary report discussed findings associated with the self-reported and survey based data collected. As such, it has inherent limitations associated with the biases of self-reported data. However, after a thorough review of the data and the conduct of its analysis, I am comfortable stating that this report provides a fair and accurate description of the pilot project results within these areas. And,

"Preliminary Report: Quantitative/ Claims Findings"

This preliminary report discusses the findings associated with the analysis of the Medicaid provided patient claims. As such, it has inherent limitations associated with the bias of population selection and the potential for low absolute numbers of patients within an individual practice causing an unfair representation of practice performance when adjusted to industry standard population-based metrics. Additionally, some payer blends may contain a single or 2 practices, limiting the ability to generalize their results. As part of the data collection process, clinics and providers were assured that their data would only be used in aggregate form, so there is extreme caution taken to limit the ability of a reader to infer direct information about a single provider or group. After a thorough review of the data and the conduct of its analysis, I am comfortable stating that this report provides a fair and accurate description of the pilot project's financial and utilization results

In its simplest description, the pilot project was a significant success with tremendous implications for the future of healthcare in Idaho. Despite the pilot project serving only ~9,000 patients, a $22 per member per month (PMPM) average savings was accomplished- resulting in approximately $2.4 million savings for IDHW over each year of the project. Extrapolating these savings to a statewide initiative has the potential for a noticeable impact on the state budget in a manner that will actually improve the healthcare of the citizens of Idaho. This report builds upon the previous to establish recommendations for how.

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Recommendations

- **Utilize the State Insurance Commissioner to Establish a State-wide Program of Quality Metrics / Reporting Requirements-** One of the greatest values of the IMHC project and the future State Health Improvement Project grant are their ability to consolidate diverse programs and requirements into a single, coherent body of work. An inherent limitation of both is their time-limited nature. The physicians within the pilot project universally commented on the difficulty of participating in disparate incentive programs and reporting on a variety of measures. The development of a standard set of measures and reporting requirements for all insurers in Idaho would allow the state to address this need, but establish a formal mechanism to ensure that payers participate.

- **Implement a process by which practices are required to establish a "patient centered budget" for incentive funds-** The addition of funds without reconsideration of practice processes is simply viewed as an increase in profit. However, requiring the consideration and presentation of a budget for utilization of incentive funds to advance care has been shown to be an effective tool. Due to findings around wages during the project, allowing a certain percent of the incentive payments (5-10%) to be used for increased wages or bonuses for staff should be considered.

- **Establish a practice level leadership development program-** Practices within the project commented that they were lacking in either the skills or experience to manage the ongoing changes. This presents both a challenge and an opportunity for the state to establish an educational program that provides both the academic knowledge and the peer networking / support required to fulfill this need.

- **Utilize "all or none" quality measures-** Utilizing single measures to assess quality allows for periodic attention to be effective. As a result, practices focus on individual measures for brief periods then move to other topics, essentially spinning plates. This is an inherently failing strategy. The implementation of metrics that require systematic change in order to consistently achieve them will establish reproducible outcomes of quality

- **Statewide public education campaign on patient portals-** Practices almost universally advised that patients had little interest in utilizing a portal. As such, practices are an ineffective way to promote this. A statewide campaign focused on "talking to your doctor" could be a potentially effective strategy for addressing both the inappropriate ER utilization rates and could drive alternative forms of communication, such as patient portals.

- **Don't rely on money as the only incentive-** Pilot project physicians were largely satisfied with their personal income, suggesting that monetary incentives would have to be quite high to have an impact on behavior. However, they rated work-life balance as a stressed area. Incentive programs that looked at the administrative requirements placed on physicians, in the name of cost savings and quality, which might be eased when physicians achieve a certain level of performance could become a national exemplar. Tasks such as medication prior-authorizations or pre-approval of certain procedures could potentially be waived for physicians with high performance. Results of the surveys suggest that would be a far more effective incentive than a payment program.

- **Statewide HIE emphasis -** A wide gulf exists between current HIE capacities and beliefs regarding those capacities across the state. Without the establishment of an effective and widely distributed HIE, or an innovative alternative solution such as patient ability to transfer their records via smart phone or smart card, Idaho is rapidly approaching the point where their innovations will be forced to a crawl. The realistic time horizon by which this must be accomplished is 3 years.

- **Tiered practice recognition-** The initial evaluation of practices within the pilot project rapidly established 3 tiers of practices, with very similar impacts and measures throughout the project. Those practices scoring higher than a 70 on the PCMH-A had limited improvement, but relatively good process measures. Those practices below 50 showed improvement, but only at an infrastructrural level and were not able to achieve excellence by the end of the project. Those in the middle tier were the greatest impacted by the project. This model should be used to define interventions in the future- High, mid and low scoring practices, according to the PCMH-A tool, should be approached differently, with different support and goals.

- **Practice Transformation Support-** During the pilot project, it became rapidly clear that additional support in the form of technical expertise and project management skills were required in order to achieve continuing success. The utilization of the Public Health Districts to provide a cadre of trained, community based practice change supporters is critical to the expandability of these results.

- **Focus on Physician Well-Being-** A high rate of physician satisfaction with their practice situation was noted across the project. However, many commented about increasing stress and work-life imbalance. A focus on physician well-being by the state medical board or statewide physician associations could be particularly useful in maintaining and increasing the number of practicing physicians in Idaho.

- **Establish community consensus guidelines for chronic disease-** Variations in practice patterns persisted throughout the project and a significant amount of the ER total cost was associated with high volumes of conditions that could be effectively managed outside of the ER. Facilitated discussions between the primary care and specialty communities to establish consensus on community-based standards of care and referral patterns could have a significant impact on reduction of both specialty demand stress and ER utilization.

- **Support, instead of direct, practices-** Practices within Idaho demonstrated a significant independence and desire to maintain a sense of autonomy. As a result, they bristled at any program that was viewed as "directive." Discussion with payers confirmed this inherent conflict. Future efforts should focus not on "how do we get doctors to…", but instead on "how can we help doctors to…"

- **Incentivize wage increases-** While physicians largely indicated acceptability of their payment, this was not universal across office staff. Medical Assistants and Clerical Staff almost uniformly felt undervalued for the work that they are accomplishing towards patient care. If not effectively addressed in the future, this will likely lead to difficulty continuing to advance care due to frequent turn-over.

- **Establish regional healthcare collaboratives-** In addition to the practice coaches, PHD's also have a great opportunity to convene physicians from across their region to share their experiences, successes and failures. The most impactful changes to practices were typically based upon a peer report of success with a particular technique. A way to identify and spread these peer successes will greatly speed dissemination.

- **Recognize the Role of Local Care Managers in the Care of High Risk Patients-** Pilot practices utilizing Care Managers had significant impacts on hospital readmissions, potentially as the result of increased contact and relationship development. However, these had limited impacts on quality measures or cost of care and had no impact on ER utilization. The tasks of Care Management, while traditionally though of at the patient level, must incorporate population health tasks when at an individual practice level. As a result, these personal must have far greater training and knowledge than required for traditional single patient care management. A program to instill this knowledge and training will be essential for future sustainability.